STATE OF ALABAMA

DEPARTMENT OF INSURANCE

REPORT OF EXAMINATION

of

HEALTHSPRING OF ALABAMA, INC.

BIRMINGHAM, ALABAMA

as of

DECEMBER 31, 2006

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EXAMINATION AFFIDAVIT

STATE OF ALABAMA
COUNTY OF JEFFERSON

Rhonda B. Ball being first duly sworn, upon her oath deposes and says:

That she is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

That an examination was made of the affairs and financial condition of HealthSpring of Alabama, Inc. for the period of January 1, 2005 through December 31, 2006;

That the following 57 pages constitute the report thereon to the Commissioner of Insurance of the State of Alabama;

And, that the statements, exhibits, and data therein contained are true and correct to the best of her knowledge and belief.

Rhonda B Ball

Rhonda B. Ball
Examiner-in-charge

Subscribed and sworn to before the undersigned authority this 25th day of April 2008.

Loni Koch

(Signature of Notary Public)

LONI KOCH, Notary Public

Printed name

in and for the State of Alabama

My commission expires MY COMMISSION EXPIRES NOVEMBER 16, 2011

GOVERNOR
Bob Riley

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
EXAMINATION DIVISION
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COMMISSIONER
Walter A. Bell

Deputy Commissioner
D. David Parsons

Chief Examiner
Richard L. Ford

State Fire Marshal
Ed Paulk

General Counsel
Reyn R. Norman

Hoover, Alabama
April 25, 2008

Honorable Walter A. Bell
Commissioner of Insurance
State of Alabama
Department of Insurance
Post Office Box 303350
Montgomery, Alabama 36130-3350

Dear Commissioner Bell:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions adopted by the National Association of Insurance Commissioners, an examination has been made of the affairs and condition of

HealthSpring of Alabama, Inc.
Hoover, Alabama

as of December 31, 2006, at its home office located at Two Chase Corporate Drive, Suite 300; Hoover, Alabama 35244. The report of examination is submitted herewith.

Where the term, Company, appears herein without qualification, it is synonymous with HealthSpring of Alabama, Inc.

SCOPE OF EXAMINATION

The examination reported herein covers the period from January 1, 2005 through December 31, 2006 and has been conducted by examiners representing the Alabama Department of Insurance. Events subsequent to December 31, 2006 have been reviewed and are reported herein as deemed appropriate.

The Company has been examined in accordance with the statutory requirements of the State of Alabama for a Health Maintenance Organization, and in accordance with applicable laws of the State of Alabama; Alabama Insurance Departmental regulations, bulletins and directives; and in accordance with the applicable guidelines and procedures of the NAIC; and in accordance with generally accepted examination standards.

The examination included a general review of the Company's operations, administrative practices and compliance with statutes and regulations. Income and disbursement items were tested for selected periods. Assets were verified and valued and all known liabilities were established or estimated as of December 31, 2006, as shown in the financial statements contained herein. However, the discussion of assets and liabilities contained in this report has been confined to those items which resulted in a change to the financial statements, or which indicated a violation of the *Alabama Insurance Code* and the Insurance Department's rules and regulations or other insurance laws or rules, or which where deemed to require comments and/or recommendations.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attested to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2006. A signed letter of representation was also obtained at the conclusion of the examination, whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, financial position of the Company, and contingent liabilities.

The market conduct phase of the examination consisted of a review of the Company's territory, plan of operation, policy forms, policyholder services, advertising and marketing, compliance with agents' licensing requirements, complaints, and the Company's compliance with the Violent Crime Control and Law Enforcement Act of 1994 (ALA. ADMIN. CODE 482-1-121 (2003)) and privacy regulations (ALA. ADMIN. CODE 482-1-122 (2001)).

ORGANIZATION AND HISTORY

The Company began operations on April 1, 1985, as a health maintenance organization, licensed by the state of Alabama. The original name of the Company was "Sunmark Health Plans."

On May 28, 1986, the Company was purchased by Baptist Health Systems, Inc. (BHS), formerly Baptist Medical Centers, and the name was changed to "Samaritan Health Plans." BHS is a non-profit corporation, which later formed a for-profit holding company, BHS Affinity, Inc. (BHSA) and transferred ownership of the Company to BHSA. On February 28, 1988, the name of the Company was changed to "Partners Health Plan of Alabama, Inc." On September 22, 1992, the Company's name was changed to "Health Partners of Alabama, Inc."

On January 1, 1995, the Company merged with Gulf Health Plans HMO, Inc. (GHP) with the Company as the surviving entity. Infirmary Health System, Inc. (IHS), parent of GHP, had its shares in GHP converted into 620 shares of the Company, making it a minority shareholder. As a result of the merger, the Company was owned 89% by BHS and 11% by IHS.

On March 1, 1995, the Company purchased a third party administrator, Gulf Health Plans, Inc., and purchased HPA Administrative Services, Inc. from BHS. Upon the effective date of the purchase, HPA Administrative Services, Inc. was merged into Gulf Health Plans, Inc. with HPA Administrative Services, Inc. as the surviving corporation. It was a wholly owned subsidiary of the Company.

On August 16, 1996, BHSA and IHS formed a holding company, Health Partners Southeast, Inc. (HPSE). BHSA and IHS each contributed their ownership interest in the Company to HPSE. Upon consummation of the transaction, HPSE became 100% owner of the Company, and HPSE was owned 89% by BHS and 11% by IHS.

On September 23, 1996, HPSE purchased PCA Health Plan of Alabama, Inc., PCA Health Plan of Georgia, Inc., and Health Strategies, Inc. The name of PCA Health Plan of Alabama, Inc. was changed to "Merit Health Plan of Alabama, Inc." (Merit). PCA Health Plan of Georgia's name was changed to "HPC Health Plans of Georgia, Inc." Both of these HMOs were affiliates of the Company. Health Strategies, Inc. was an affiliate of the Company.

On April 28, 1998, an Order to Show Cause concerning the violation of Alabama Department of Insurance Regulation No. 101, Hazardous Financial Condition was issued due to the Company's losses exceeding 50% of its net worth as stated in the 1997 Annual Statement. As a result, monthly financial statements were sent to the Department. The Order was lifted May 7, 1999, due to the sworn statement by BHS's Chairman, Mr. Green, that BHS would continue to financially support the Company as long as it was owned by the Hospital. The Commissioner required the Company to maintain a $3 million stand-by letter of credit in favor of the Alabama Insurance Department as an added precaution against the violation of the aforementioned regulation.

On April 14, 1999, at a Form A hearing, BHS purchased the remaining 11% of HPSE from IHS. The purchase price was an agreement and a guarantee that the full and prompt payment of $23 million in notes issued by HPSE pursuant to the terms of a fiscal agency agreement dated August 1, 1996 between HPSE and AmSouth Bank of Alabama would be paid in full. As of April 14, 1999, HPSE was a wholly owned subsidiary of BHS.

On September 30, 1999, the Company merged with Merit. The Company remained as the surviving corporation after the merger. The outstanding shares of Merit were cancelled as of September 30, 1999, and HPSE owned 5,000 shares of the Company.

On March 10, 2000, an Order to Show Cause for violating Alabama Department of Insurance Regulation 101, Hazardous Financial Condition, was issued because the Company's losses exceeded 50% of its net worth as stated in its 1999 Annual Statement. A hearing to suspend the certificate of authority was set for April 11, 2000. On March 31, 2000, a Continuation of the Notice of Hearing was made and granted until such time as a Form A hearing on the acquisition of the Company could be scheduled.

On March 24, 2000, BHS received a letter of intent from Venture Health Partnership Group, LLC (VHPG), a Delaware limited liability company, to purchase all the issued and outstanding shares of capital stock and assets of Health Partners Southeast, Inc. (HPSE).

On June 8, 2000, a Form A hearing was held at the Alabama Department of Insurance, in which the sale of the Company was approved by the acting Alabama Insurance Commissioner to be effective on June 1, 2000. At said meeting, a document illustrating the breakdown of payments made and to-be-made by BHS was distributed. BHS made two capital contributions in the

amounts of $5,643,000 and $18,420,771 prior to closing the sale. Part of the contributions was used to write down the affiliate receivables for BHS, Baptist Medical Centers, Montclair Hospital, and Princeton Hospital.

On November 13, 2000, the Company's name was changed to The Oath- A Health Plan for Alabama, Inc.

On March 23, 2001, an Order to Show Cause for violating Alabama Department of Insurance Regulation 101, Hazardous Financial Condition, was issued because the Company's losses exceeded 50% of its net worth as stated in its 2000 Annual Statement. A hearing to suspend the Company's certificate of authority was set for April 18, 2001. On April 18, 2001, a Continuation of the Notice of Hearing was made and no new hearing date was set at that time.

On June 5, 2001, a Notice of Continuation of Hearing was made and a hearing date was rescheduled for July 11, 2001. This hearing was cancelled and another Order to Show Cause was issued on September 4, 2001.

On September 5, 2001, an Order was issued to immediately cease paying any monies out of the Company for any and all consulting fees due to the Company continuing to be in a hazardous financial condition, which was placing the enrollees at risk. Additionally, all administrative expenses, prior to being paid, were to be reviewed by Ms. Denise Azar, Acting Chief, Receivership Division of the Department.

A hearing was set for September 18, 2001, but then was rescheduled for September 20, 2001. At the September 20, 2001 hearing, there was sworn testimony by Company officials that within five days approximately $1.5 million would be wire transferred into the Company and then disbursed for settlement in the dispute with Baptist Health Systems, Inc. Additional testimony indicated other steps being taken to provide further infusion of capital into the Company, so as to resolve its financial impairment. The Commissioner agreed, at the close of the hearing, to leave the record open in this proceeding until October 11, 2001, for the purpose of receiving additional documentation to evidence the Company's testimony.

On September 24, 2001, it was ORDERED that the record would remain open until October 11, 2001, to permit Company representatives to file additional documentary evidence in support of their position and testimony noted above at the September 20, 2001 hearing. It was also ORDERED that the Company immediately cure its financial impairment and provide evidence to the

Department that this had occurred, no later than September 25, 2001. This evidence was to include a September 30, 2001 *pro forma* balance sheet indicating the Company's expected financial condition. The Commissioner also REQUESTED the Company to voluntarily stop the marketing of its products to new groups. It was also ORDERED that until further supporting information was received and reviewed by the Department, the management agreement between the Company and Scheur Management Group (SMG) was hereby DISAPPROVED. No further payments were to be made by the Company to SMG under this agreement until further ordered. The Commissioner ORDERED that the Company immediately provide documentation regarding each consultant employed with the Company under the management agreement to include each consultant's position or job title, time sheets for the consultants' work schedule at the Company, and copies of any documentation evidencing the work product of these consultants.

On October 17, 2001, an ORDER was issued stating that the Company had until November 15, 2001 to file its September 30, 2001 financial statement and submit additional documentary evidence including actuarial studies to support the financial assumptions indicating whether additional funds were needed to remain solvent into the foreseeable future, in which case said additional funds should be infused into the Company no later than November 20, 2001; that beginning November 2001 through and including April 2002, the Company would submit certified monthly financial statements using the format of the National Association of Insurance Commissioners quarterly statement blank (jurat page and first seven pages), to be filed within thirty days of the end of the next month; and, that the Company would continue to be under the oversight of the Department pursuant to the terms of the Agreement to Continue Hearing dated July 11, 2001.

In October 2001, a surplus note was issued by Venture Health Partnership Group, Inc., in order to meet the minimum statutory requirements by the Alabama Department of Insurance.

On June 6, 2002, an order to Show Cause was issued because of the Company's financial statement as of April 30, 2002, which showed the capital and surplus was impaired by approximately $614,162. On June 28, 2002, the Order to Show Cause was lifted.

On November 19, 2002, NewQuest, LLC acquired the Company and changed the Company's name to HealthSpring of Alabama, Inc.

On January 1, 2003, NewQuest Management of Alabama, LLC was formed to act as a management company for the Company.

HealthSpring, Inc. was formed in October 2004 in connection with a recapitalization transaction which was accounted for using the purchase method, involving the Company's parent, NewQuest, LLC, its members, GTCR Golden Rauner II, L.L.C., a private equity firm, and its related funds, or the GTCR Funds, and certain other investors and lenders. The recapitalization was completed in March 2005.

Currently, the Company is owned 100% by NewQuest, LLC. NewQuest, LLC is owned 100% by HealthSpring, Inc. HealthSpring, Inc. issued an initial public offering on February 8, 2006 and is listed under the symbol HS on the New York Stock Exchange. In connection with the initial public offering, HealthSpring, Inc. sold 10.6 million shares of common stock at a price of $19.50 per share. The total proceeds to HealthSpring, Inc. were $188.7 million, net of the $18.0 million of offering costs. From the offering and available cash, HealthSpring, Inc. repaid all of its long-term debt and accrued interest, including a $1.1 million prepayment penalty, totaling $189.8 million. Additionally, HealthSpring, Inc. issued approximately 12.6 million shares of common stock in exchange for all of the outstanding preferred stock, including dividends.

The Company's authorized capital stock consisted of 120,000 shares of common stock. At December 31, 2006, there were 5,620 shares issued and outstanding at $20 stated value per share resulting in $112,400 issued and outstanding.

GROWTH OF THE COMPANY

The following schedule presents financial data, which reflects the growth of the Company for the years indicated:

Year	Premium & Related Revenue	Admitted Assets	Liabilities	Capital & Surplus
2004*	$134,978,713	$25,539,750	$19,261,867	$ 6,277,883
2005	195,712,594	40,015,339	29,203,969	10,811,370
2006*	$284,667,228	$89,337,741	$62,101,310	$27,236,431

*Data for the years 2004 and 2006 were per examinations. Data for 2005 was obtained from the 2005 Annual Statement.

SURPLUS

Sources of Capital and Surplus

The Company's authorized capital stock consisted of 120,000 shares of common stock, of which 5,620 were outstanding. At December 31, 2006, common capital stock consisted of $112,400 derived from 5,620 shares at a stated value of $20 per share. Gross paid in and contributed surplus was $5,010,875. Capital and surplus amounts were increased by an unassigned funds (surplus) amount of $25,178,214, resulting in total capital and surplus in the amount of $30,301,489, per the Company's 2006 Annual Statement. Examination adjustments reduced the Company's capital and surplus to $27,236,431.

The Company experienced net income of $2,953,662 and $18,857,452 for 2005 and 2006, respectively. Examination adjustments decreased the Company's 2006 net income to $15,792,394.

STATUTORY DEPOSITS

In accordance with the requirements of ALA. CODE § 27-21A-12 (1975), as amended, the Company maintained the following deposits with the State of Alabama, at December 31, 2006:

	Par Value	Statement Value	Market Value
Regions Bank, CD	$ 200,000	$ 200,000	$ 200,000
Regions Bank, CD	800,000	800,000	800,000
Total	$1,000,000	$1,000,000	$1,000,000

CORPORATE RECORDS

The Alabama Department of Insurance, effective November 19, 2002, permitted NewQuest, LLC to purchase the Company from Venture Health

Partnership Group, LLC. The Company's Certificate of Incorporation, By-laws and related amendments were inspected and were found to provide for the operation of the Company. There were no amendments made during the examination period.

Records of the meetings and actions of the Company's corporate bodies, since December 31, 2004, were reviewed. The records appeared to be complete and accurately reflect the actions of the respective corporate bodies with the exception of the following:

- A review of the Board of Directors meeting minutes indicated that the Company held its annual Board of Directors meeting in February 2005 and 2006. There was no evidence of any Shareholder meetings during the examination period. This is a violation of the Company's By-laws which state that the Company will hold an annual meeting of its shareholders for the election of directors and the transaction of general business in January of each year. The By-laws also state that the annual meeting of the Board of Directors will be held immediately following the annual shareholder's meeting for the purpose of electing officers and the transaction of other business.
- Review of the minutes of the Board of Directors indicated that no investments were approved or ratified by the Board of Directors for the period under examination, which was in conflict with ALA. CODE § 27-41-5(1975), which requires that:

  > "An insurer shall not make any investment or loan, other than loans on policies or annuity contracts, unless the same be authorized, approved or ratified by the board of directors of the insurer or by such committee..."

MANAGEMENT AND CONTROL

Stockholder

At December 31, 2006, NewQuest, LLC owned 100% of the Company's common capital stock.

Board of Directors

According to the Company's Charter and By-laws, the board of directors shall manage its business and dealings. Since there were no shareholder minutes

during the examination period, the following were represented by Company management as serving as Company directors at December 31, 2006:

Director/Address	Principal occupation
Herbert Allen Fritch Nashville, Tennessee	Chairman/Chief Executive Officer/Managed Care Executive of HealthSpring affiliates
Rene Philip Moret Birmingham, Alabama	President HealthSpring of Alabama, Inc. and NewQuest Management of Alabama, LLC.
Kevin Michael McNamera Brentwood, Tennessee	Chief Financial Officer HealthSpring affiliates
Jeffrey Lynn Rothenberger Nashville, Tennessee	Managed Care Executive HealthSpring affiliates
John Murray Blackshear Nashville, Tennessee	Retired Former President of HealthSpring of Tennessee, Inc.

The Company's Board at December 31, 2006 consisted of five directors instead of only three as was required by the Company's Articles of Incorporation and the Company's Bylaws. Also, Herbert A. Fritch was the Company's CEO and Rene Moret was the Company's President, which was in conflict with Article V Section 3 (b) of the Company's Bylaws, which states: "The President shall be the chief executive officer of the corporation..."

Committees

The Company had no Board committees during the examination period. The following are the committees that the Company had in place at December 31, 2006 in accordance with Department of Public Health standards:

Executive Oversight Committee
Medical Advisory Committee
Credentialing Committee

Minutes were provided for these committees for the period under examination. The following members were serving at December 31, 2006:

Executive Oversight Committee

Rene Moret- Chairperson
Ron Vines
Jamey Vella
Sheffield Young
Robert Davis
David Beauchaine
Robin Ousley
Cheryl DeBold
Winona Angelo
Danielle Cooke

Medical Advisory Committee

Richard P. McLaughlin, MD, Acting Chairman & Medical Director
Theodis Bugs, MD
Paul Scalici, MD
C. Michael Buchanan, MD
William Edge, MD
Edward Mahan, MD
Thomas Moody, MD
Rene Moret, President
Cheryl DeBold, RN, VP Health Services
Winona Angelo, RN, Manger, QI
Deborah Belding, LPN, QI Coordinator
Sheffield Young, Director of Network Operations

Credentialing Committee

Richard P. McLaughlin, MD, Acting Chairman & Medical Director
Joseph Wu, MD, Internal Medicine
A. Mahender Reddy, MD, Cardiovascular Disease
Jacqueline Stewart, MD, Pediatrics
E. Scott Elledge, MD, Otolaryngology
H Morgan Ashurst, MD, Geriatric Medicine
John C. Foster, MD, OB/GYN
Robert S. McCord, MD, Vascular Surgery

Officers

According to the Company's February 14, 2006 Board of Directors minutes, the following officers were elected and were serving at December 31, 2006:

Herbert Allen Fritch	Chairman/CEO
Jeffrey Lynn Rothenberger	Secretary
Rene Philip Moret	President
Teresa Reardon Jamieson Jordan	Assistant Secretary
Kevin Michael McNamara	Treasurer
David Ironside Beauchaine	Chief Financial Officer
Hugh Marvin Hood, MD	Medical Director

The Company did not have a Vice-Chairman at December 31, 2006, which was required by Article V Section 1 of its By-laws.

Conflict of Interest

The Company did not provide signed conflict of interest statements completed by all of its officers and directors for the examination period. Signed 2005 conflict of interest statements were not provided for Herbert Fritch, Jeffrey Rothenberger, Steven Adams, or Bradley Green. Signed 2006 conflict of interest statements were not provided for Herbert Fritch or Jeffrey Rothenberger. Not maintaining signed conflict of interest statements from all of its officers and directors was noted in the prior examination report.

HOLDING COMPANY AND AFFILIATE MATTERS

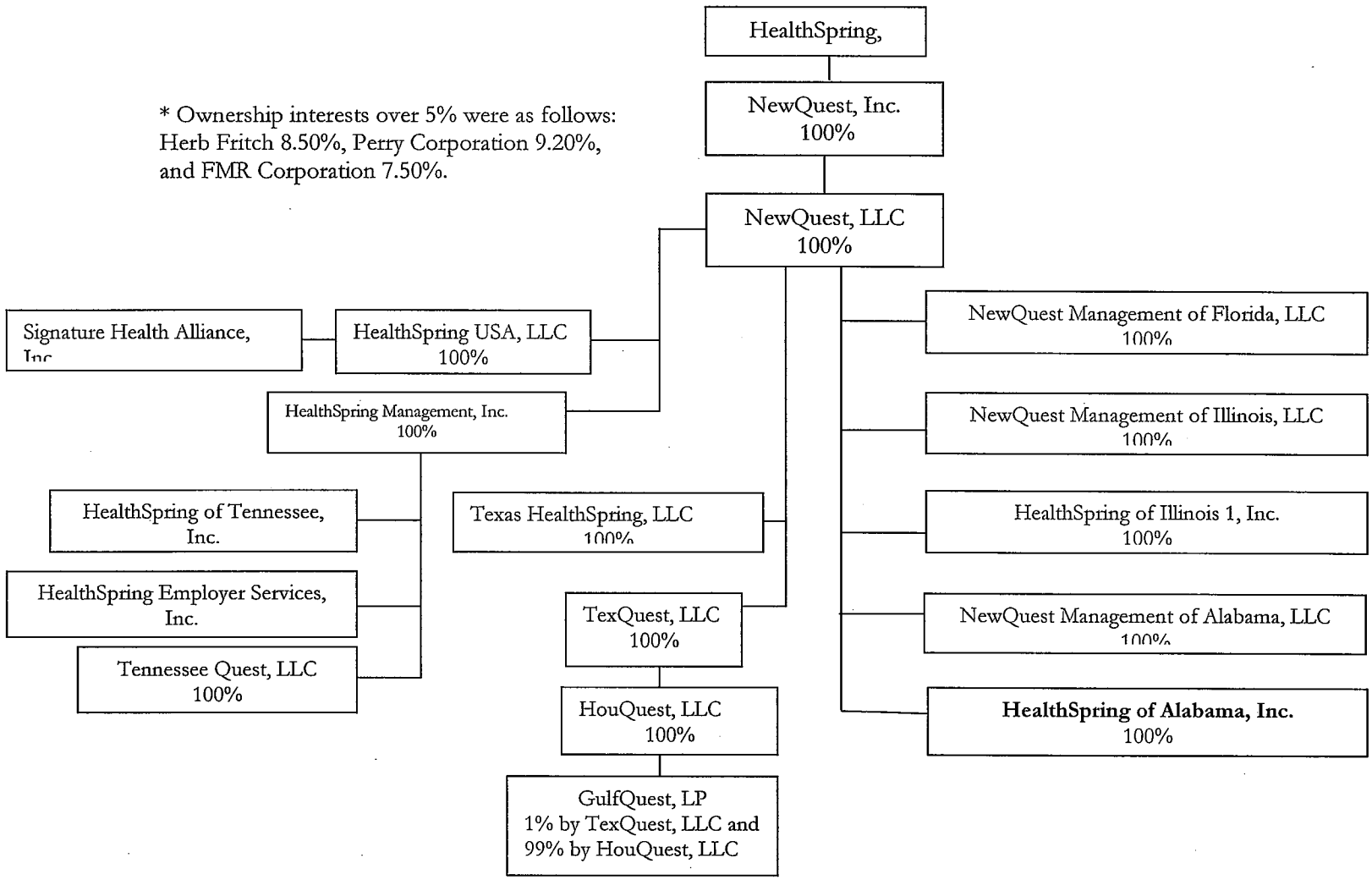
Holding Company Registration

The Company was not subject to the *Alabama Insurance Holding Company Regulatory Act*, as defined in Section 27-29-1, Code of Alabama 1975, as amended, except as expressly required by other statutes and regulations. Generally, HMOs are subject to regulation in regard to changes in control, but are not subject to the continuing holding company reporting requirements that apply to insurance companies.

Organizational Chart

The Company did not complete its 2006 Schedule Y- Part 1 in accordance with the NAIC Annual Statement Instructions. The Company's 2006 Schedule Y-Part 1 did not reflect the controlling persons of HealthSpring, Inc. The persons with over 5% ownership were as follows: Herbert Fritch (8.50%), Perry Corporation (9.20%), and FMR Corporation (7.50%).

The following chart presents the identities of and interrelationships among all affiliated persons within the Insurance Holding Company System at December 31, 2006 and includes the ultimate controlling person:


* Ownership interests over 5% were as follows: Herb Fritch 8.50%, Perry Corporation 9.20%, and FMR Corporation 7.50%.
HealthSpring,
NewQuest, Inc. 100%
NewQuest, LLC 100%
Signature Health Alliance, Inc
HealthSpring USA, LLC 100%
HealthSpring Management, Inc. 100%
HealthSpring of Tennessee, Inc.
HealthSpring Employer Services, Inc.
Tennessee Quest, LLC 100%
Texas HealthSpring, LLC 100%
TexQuest, LLC 100%
HouQuest, LLC 100%
GulfQuest, LP 1% by TexQuest, LLC and 99% by HouQuest, LLC
NewQuest Management of Florida, LLC 100%
NewQuest Management of Illinois, LLC 100%
HealthSpring of Illinois 1, Inc. 100%
NewQuest Management of Alabama, LLC 100%
HealthSpring of Alabama, Inc. 100%

Management and Service Agreements

At December 31, 2006, the Company was a party to the following agreements with its related parties:

Management services agreement between NewQuest Management of Alabama, LLC and HealthSpring of Alabama, LLC

The agreement was effective January 1, 2003. Throughout the agreement, HealthSpring of Alabama, Inc. was referred to as ("HealthSpring") and NewQuest Management of Alabama, LLC was referred to as ("Manager").

- 2.1- Manager is the sole and exclusive agent for management and administration of certain business functions for HealthSpring.
- 2.2- Authority was delegated to Manager and HealthSpring without restriction.
- 3.1- Manager shall provide management and administrative services in accordance with HealthSpring's operational needs, laws, rules, and regulations.
- 3.2- Manager shall assist HealthSpring to establish and monitor procedures that promote the consistency, quality, and appropriateness of health care.
- 3.3- Manager shall maintain all regulatory permits for the operation of HealthSpring.
- 3.4.1- Manager is responsible for all aspects of its personnel.
- 3.6- Manager shall act under special powers of attorney for HealthSpring and have access to HealthSpring's bank account.
- 3.7.1- HealthSpring shall deliver an annual fiscal operational budget to Manager 60 days in advance.
- 3.7.2- Manager shall administer all accounting procedures and controls. Manager shall supervise the preparation and deliver to HealthSpring end of year and monthly statements.
- 3.7.3- HealthSpring has the right to examine and audit all accounts maintained by Manager.
- 3.8- Manager shall be responsible for all HealthSpring tax returns and reports.
- 3.9- Manager shall create, prepare, and file timely reports and records on HealthSpring's behalf.
- 3.11- Manager shall keep HealthSpring information confidential.
- 3.12- Manager shall maintain its own insurance.

- 3.14- Manager shall be responsible for the preparation of all premium tax and regulatory assessment filings at its own expense. At HealthSpring's request, Manager shall, at HealthSpring expense, file protests and applications regarding government of taxing authorities.
- 3.16- All personal property, lease payments either for real estate or equipment, shall be at Manager's expense, even if the lease is in HealthSpring's name.
- 4.2- HealthSpring shall arrange for medical care through its providers.
- 4.6- HealthSpring shall at its own expense maintain appropriate insurance.
- 5.1- HealthSpring agrees to pay Manager monthly management fees by the 10th of each month as evidenced in Exhibit A.
- 6.1- The agreement is binding for one year and shall be reviewed each year or within 60 days notice of cancellation.
- 6.2.2- If either party defaults, it has 30 days, or 10 days for nonpayment of fees, to cure the default.
- 6.3.1- Upon termination of the agreement, neither party shall have any further liabilities except those accrued. Promises and covenants expressly made to extend beyond the termination date shall remain in force.
- 8.1.1- This agreement supersedes all previous agreements.

Amendments to management services agreement by and between HealthSpring of Alabama, Inc. and NewQuest Management of Alabama, LLC

Within the amendments, HealthSpring of Alabama, Inc. is referred to as HealthSpring and NewQuest Management of Alabama, LLC is referred to as Manager.

Effective January 1, 2004, the management services agreement shall be amended as follows:

- Section 3.12- Manager's Insurance shall be deleted and replaced in its entirety with Section 3.12- Manager's Insurance as set for in this amendment, effective January 1, 2004. Section 3.12- Manager's Insurance- Throughout the Term, Manager shall, at HealthSpring's expense, obtain and maintain with commercial carriers, self-insurance or some combination of these, appropriate workers' compensation coverage for Manager's employed personnel provided pursuant to this Agreement, and casualty and comprehensive general liability insurance, including an employee dishonesty policy, covering Manager, Manager's personnel and

all of Manager's equipment in such amounts, on such basis and upon such terms and conditions as Manager deems appropriate.

The management fee reimbursement schedule was amended effective January 1, 2004, 2005 and 2006.

The management services agreement and the amendments to the management agreement were approved by the Alabama Department of Insurance.

Tax Sharing Agreement between NewQuest Holdings, Inc. and the Company

The agreement was entered into effective March 1, 2005, by and between NewQuest Holdings, Inc. (Parent) and the Company along with other affiliated parties (Group).

(1) The Parent will include the Company within a consolidated income tax return beginning with the taxable year ending December 31, 2005.

(2) Within 120 days after the end of each consolidated return year, the Company shall pay to Parent the amount (if any) of its "Separate Return Tax Liability," which shall mean the federal income taxes for which the Company would have been liable for that year if the Company were filing a separate tax return under the Code. For the purposes of determining the Company's Separate Return Tax Liability:
(a) Any dividends received by one member of the Group from another member of the Group will be assumed to qualify for the 100 percent dividends received deduction of Section 243 of the Code, or shall be eliminated from such calculation in accordance with Section 1.1502-14(a)(1) of the Regulations.
(b) Gain or loss from intercompany transactions, whether deferred or not, shall be treated by each member of the Group in the manner required by Section 1.1502-13 of the Regulations.
(c) Limitations on the calculation of a deduction or the utilization of tax credits or the calculation of a tax liability shall be made on a consolidated basis.
(d) Elections as to tax credits and tax computations that may have been different from the consolidated treatment if separate returns were filed shall be made on an annual basis by Parent.

Furthermore, in the event the Company would have had a net operating loss or tax credit for any consolidated return year, and that loss or credit is actually used by the Group to reduce the Group's consolidated federal income tax liability,

Parent shall contribute to the Company's capital an amount that is consistent with the terms of this Agreement. An amount generally will be deemed consistent and reasonable if paid on a basis equal to 35% of net operating losses utilized and 100% of credits utilized.

(3) Prior to the end of any consolidated return year, the Company shall advance to Parent (within a reasonable period after request by Parent) amounts necessary to reimburse Parent for that portion of any estimated federal income tax payments attributable to the inclusion of the Company in the Group. Any amounts so paid in any year shall operate to reduce the amount payable to Parent following the end of such year pursuant to Section 2, and any balance resulting from such reduction shall be promptly refunded by Parent to the Company.

(4) In the event of any adjustment to the tax returns as filed (by reason of an amended return, claim for refund, or an audit or administrative adjustment by the Internal Revenue Service (IRS)), the liability of Parent and Company shall be redetermined to give effect to any such adjustment as if it has been made as part of the original computation of tax liability, and payments between the Parent and the Company shall be made within 120 days after any such payments are made or refunds are received, or, in the case of contested proceedings, within 120 days after a final determination of the contest. Parent shall have the sole authority to enter into a settlement agreement with the IRS that purports to bind any member of the Group and to enter into an agreement extending the statute of limitations as contemplated by Section 6229 (b)(i)(B) of the Code.

(5) A dispute or difference between the parties with respect to the operation or interpretation of this Agreement which has not been resolved through negotiation between the parties shall be settled and determined through arbitration in accordance with the Rules of Commercial Arbitration of the American Arbitration Association.

(6) This Agreement shall be binding on and inure to the benefit of any successor, by merger, acquisition of assets or otherwise, to any of the parties hereto, to the same extent as if such successor had been an original party to the Agreement.

Management services agreement between NewQuest Management of Alabama, LLC and HealthSpring USA, LLC

The Company was not a party to this agreement; however, it was named within the service agreement.

This agreement is between NewQuest Management of Alabama, LLC (Manager) and HealthSpring USA, LLC, a Tennessee limited liability company (HealthSpring USA). The effective date was January 1, 2004 with an execution date of May 20, 2004.

- HealthSpring USA and Manager mutually desire an arrangement that facilitates the management and administration of claims processing and information technology business operations of HealthSpring of Alabama (HMO) which is the health maintenance organization that has contracted with Manager for the provision of all management functions.
- Manager desires to engage HealthSpring USA to provide such management and administrative services as are necessary and appropriate for the administration of HMO's Alabama business;
- 2.2- Authority- HealthSpring USA shall have the responsibility and commensurate authority to provide management and administrative services for HealthSpring of Alabama, including, without limitation, the management of risks that HealthSpring has undertaken as third party providers and the negotiation, monitoring and the quality assurance of contracts with third party providers. HealthSpring USA shall provide support services, personnel, administration of claims processing and adjudication, data processing, and other business office services as necessary. Manager is expressly authorized to provide such services in any reasonable manner. Manager deems appropriate to meet the day-to-day requirements of the business functions of HealthSpring of Alabama in accordance with Alabama law, rule or regulation.
- 3.3 - HealthSpring USA Personnel-
    - 3.3.1- Management Personnel- HealthSpring USA shall employ and otherwise retain, at HealthSpring USA's expense, and shall be responsible for selecting, training, supervising and terminating all personnel of HealthSpring USA deems reasonably necessary and appropriate for performance of its duties and obligations under this agreement. HealthSpring USA shall have sole responsibility for determining the salaries and benefits of all such management and administrative personnel, for paying such salaries and providing such

benefits, and for withholding, as required by law, any sums for income tax, unemployment insurance, social security, or any other withholding required by applicable law or governmental requirement.

- 3.4- Administration of Funds- HealthSpring USA shall have access to the HMO account, to the extent necessary to issue claims payments on the HMO's claims. Such account shall be maintained at the bank in Alabama selected by Manager and approved by HealthSpring of Alabama.
- 3.5.1- Accounting and Financial records- Manager shall establish and administer accounting procedures, controls, and systems for development, preparation and safekeeping of records and books of account relating to the provision of services under this agreement.
- 4.2- Manager's Insurance- Throughout the Term, Manager shall, at Manager's expense, obtain and maintain with commercial carriers, self-insurance or some combination of these appropriate workers' compensation coverage for Manager's employed personnel, if any, provided pursuant to this agreement, and casualty and comprehensive general liability insurance covering Manager, Manager's personnel and all of Manager's equipment in such amounts, on such basis and upon such terms and conditions as the Manager's Board deems appropriate.
- 5.1- Expenses- HealthSpring USA shall pay the expenses and disbursements in connection with provision of its services except as otherwise set forth in this agreement. HealthSpring of Alabama, the Alabama Department of Public Health, and/or Alabama Dept of Insurance or their designee shall have access to reports as necessary to ensure all expenses being charged to the Manager and subsequently the HMO are appropriate and supported by relevant detail.
- 5.2- Management fees- Manager agrees to pay to HealthSpring USA a monthly management fee equating to the direct costs for the administration of services of HealthSpring USA for the previous month as detailed on a report with sufficient detail to reflect the costs by the 10th day of each month.
- 6.1- Initial and renewal term- The term of this agreement will be for an initial period of one year and shall be automatically renewed for 1 year periods thereafter unless either party gives 120 day advance written notice of cancellation.
- 6.2- Termination-
    - 6.2.2- Termination on notice for default- If either party defaults in the performance of any obligation under this agreement, the other party shall provide written notice detailing such default. The defaulting party shall have 30 days, or 10 days in the event of nonpayment of

fees, following the giving of written notice of such default by the other party, to cure the default.

- 8.1- Independent relationship- It is mutually understood and agreed that HealthSpring USA and Manager are at all times acting and performing as independent contractors with respect to each other, and nothing in this agreement is intended and nothing shall be construed to create an employer/employee, partnership or joint venture relationship.

EMPLOYEE WELFARE

All individuals who performed administrative and operational functions for the Company were employees of NewQuest Management of Alabama, LLC. These employees were offered the following benefits:

- Paid Time Off (Personal Vacation Days and Sick Days)
- Company Holidays
- Military Leave
- Bereavement Leave
- Civic Responsibilities
- Family and Medical leave
- Health and Dental Plans
- Vision Care
- Basic Group Life Insurance
- 401(k) Plan
- Employee Assistance Program
- Short and Long Term Disability
- Health Care Spending Account
- Education Benefits.

FIDELITY BOND AND OTHER INSURANCE

The Company was a named insured on a financial institution bond issued by Federal Insurance Company, which met the suggested minimum requirements of the NAIC Financial Examiners Handbook. In addition to the aforementioned fidelity bond, the Company also maintained the following coverages to protect the Company against hazards to which it may be exposed:

- Management Liability
- Executive and Organization Liability
- Director's and Officers' (D&O) Liability Loss Prevention Services
- Employment Practices Liability Loss Prevention Services
- Business and Personal Property Coverage
- Commercial Crime Coverage
- Managed Care Organization Errors and Omissions (E&O)
- Fiduciary Liability Loss Prevention
- General Liability/Auto
- General Liability/Umbrella
- Worker's Compensation

The coverages and limits carried by the Company were reviewed during the course of the examination and appeared to adequately protect the Company's interests at the examination date.

REINSURANCE

Assumed Reinsurance

The Company did not assume any reinsurance during the examination period.

Ceded Reinsurance

During the course of this examination, the agreement in effect during 2006 was reviewed with regard to type, limits, and pertinent safeguards. The Company ceded reinsurance under an Excess HMO Reinsurance Agreement with Standard Security Life Insurance Company of New York. The following reinsurance contract was applicable at December 31, 2006.

Terms of Coverage	12 months at January 1, 2006
Coverage	Commercial business
Limits on Coverage	$1,000,000 per member per year in excess of $175,000 per member per year.

The reinsurance contract contained an insolvency clause, which provided for reinsurance payments to a receiver or statutory successor without diminution because of the insolvency of the reinsured. No reserve credits were taken for

reinsurance ceded by the Company during the examination period. The Company did not submit this reinsurance agreement to the Alabama Department of Insurance for approval. This was not in accordance with ALA. CODE § 27-21A-2 (e) (1986), which states:

> "An applicant, or a health maintenance organization holding a certificate of authority granted hereunder shall file with the commissioner all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modification thereto must be approved by the commissioner."

The Company did not disclose the general interrogatories and responses thereto within Note 23 in its 2006 Notes to the Financial Statement in accordance with the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual- SSAP No. 61, paragraph 60. This was also noted in the prior examination report.

The Company also incorrectly included its 2006 reinsurance premiums of $163,563 as negative recoveries within its 2006 Statement of Revenue and Expenses and as negative premiums paid within its 2006 Schedule S- Part 3- Section 2. These ceded premiums paid should have been reported as a reduction to premium income within the Statement of Revenue and Expenses and as positive within Schedule S- Part 3- Section 2 in accordance with the NAIC Annual Statement Instructions. This amount was determined to be immaterial.

MARKET CONDUCT

Because the Company discontinued offering insurance for small groups and individuals in June 2006, there was only one large group active at December 31, 2006, and the Company's primary focus was on its Medicare Advantage product, the examiners limited their review to the following captioned items:

Advertising and Marketing

During the examination period, the Company marketed it products through the use of printed sales brochures provided for distribution via its agency force, a publicly accessible website, and television commercial ads. The Company utilized both independent and captive (in house) agents to market and solicit its business. The Company's advertising materials included the Company's name

and address and identified what policy was being advertised. The Company appropriately disclosed its name and address; cited the source of statistics used in print ads; and included a notation indicating the manner and extent of distribution and the form number of the contract or health service plan advertised. The Company's advertisements did not misrepresent policy benefits forms or conditions, make unfair or incomplete comparisons with other policies, or make false, deceptive or misleading statements or representations.

Complaint Handling

The Company recorded complaints that were reported to the Alabama Department of Insurance, Alabama Department of Public Health and complaints that were reported directly to the Company. A total of 33 complaints were received from regulatory agencies. The examiner reviewed these 33 complaints to determine the adequacy of the documentation, the timeliness of the Company's response and the adequacy of the steps to finalize and dispose of the complaint. It was determined that policyholder complaints were responded to in a timely manner and the Company's responses appropriately addressed the issues raised by complainants. The Company maintained adequate complaint procedures in accordance with ALA. CODE 27-21A-10 (1986), which requires that:

> "(a)(1) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner, after consultation with the State Health Officer, to provide reasonable procedures for the resolution of written complaints initiated by enrollees."

The examiner also reviewed a sample of fifty complaints that were consumer direct complaints and/or grievances out of a population of 1,272 to determine the adequacy of the documentation, the timeliness of the Company's response and the adequacy of the steps to finalize and dispose of the complaint. For the sampled files selected, the Company could not provide six of the complaint files. The Company did not comply with the requirements of ALA ADMIN CODE 482-1-079-.15 (1987), which states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Also the Company did not provide enrollees and members with the contact information for the Alabama Department of Insurance - Consumer Division, when complaints were made. This was also noted in the prior two examinations.

Recording required information in the regulated entity complaint register:
The Company maintained two complaint registers: (1) Commercial/ Medicare Provider maintained by the Government Programs Department and (2) Appeals/Grievances maintained by the Solutions Unit Department. From a review of these registers, the examiners determined the following:

- The Commercial/Medicare Provider complaint register did not include the disposition in accordance with the guidelines of the NAIC Unfair Trade Practices Act, Section 4. According to this guidance, the Company is required to include in its complaint register the following information: "This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint."
- Also, the Commercial/Medicare Provider register did not include: complaint form (how the complaint was received), the type of coverage, and complainant type in accordance with the guidelines of the NAIC Market Conduct Examiners Handbook, which states: "All complaints are recorded in the required format on the Company Complaint Register." The Company's complaint register is required to include the following: the complainant's first and last name, type of coverage, date of complaint, policy number, complaint form (how the complaint was received), type of complaint, disposition, date of response, and complainant type.
- From a review of the Solutions Unit complaint register, the complaint form (how the complaint was received) was not included.

Compliance with ALA ADMIN CODE 482-1-121 (2003)

The Company did not fully comply with the requirements of ALA. ADMIN. CODE 482-1-121 (2003), which requires that:

"Failure to inform the Department of a prior felony conviction on a license application could result in a violation of this statute, as well as constitute grounds for denial of an insurance license. Insurance companies, as well as persons employing anyone to conduct the business of insurance may be in violation of this statute if they willfully permit participation by a prohibited person, including persons who are already employed or being considered for employment. Failure to initiate a screening process in an attempt to identify prohibited persons in current or prospective employment relationships may be a factor in determining if a violation of this statute has occurred."

The Company has a screening process in place for new hires; however, there is no screening mechanism in place for existing employees. Subsequent to the examination date, the Company implemented an annual questionnaire for existing employees to be in compliance.

The Company's employment application met the requirement of the initial screening process by asking prospective applicants the following: "Are you currently charged or under investigation for any violation of the law other than minor traffic violations?" and "Have you been convicted of any criminal offense, either misdemeanor or felony or subjected to deferred adjudication, other than minor traffic violations?" Also as a part of the Company's pre-employment process, applicants are required to sign the "Authorization for Background Check." The authorization for background check included the same questions as the employment application.

Compliance with ALA ADMIN CODE 482-1-122 (2001)

The Company does not disclose any nonpublic personal financial information to nonaffiliated third parties. The Company documented in its Corporate Privacy policies and procedures the steps taken to safeguard confidential member information, such as: disposing of member information in a secure shred bin or shredded prior to disposal; imposing strict guidelines for employees to adhere to when discussing member information; maintaining personal work areas in order to minimize disclosure of individually identifiable health information (IIHI); maintaining employee only access to the office premises; and, establishing IIHI confidentiality and disclosure guidelines. The Confidentiality and Disclosure guidelines include that all IIHI is required to be held in confidence by all employees working on behalf of the Company. IIHI shall not be disclosed to any person in any manner (written, verbal, or electronically).

IIHI shall only be disclosed as required by law, to another employee only for the administration of a member's account, internal operations purposes such as: grievances & appeals, quality assurance, auditing, and Company financial rights and responsibilities. However, the Company also indicated in the privacy policy that member information may be disclosed for treatment, payment, health care business operations, public health activities, where required by law, health oversight activities, judicial and administrative proceedings, law enforcement purposes, decedents, organ donation, research, averting a serious health threat, specialized government functions, enrollment/disenrollment, friends and family members, de-identified information, and health-related benefits or services.

The Company appropriately trained its employees, indicated the authorized personnel that have access to personal health information, and established that the Company does have security practices and procedures in place in compliance with ALA. ADMIN. CODE 482-1-122-.07 (2001), which states:

> "(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following: (a) Describes in general terms who is authorized to have access to the information. (b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy..."

The Company has appropriate policies and procedures in place for the protection against the disclosure of member's nonpublic personal medical information. The Company does not collect or disclose any nonpublic personal financial information. The Company's Privacy Notice content and notice delivery procedures complied with ALA. ADMIN. CODE 482-1-122 (2001). The Company also complied with the Health Insurance Portability and Accountability (HIPAA) privacy rule as promulgated by the U.S. Department of Health and Human Services.

Territory and Plan of Operation

The Company was licensed to transact business in the State of Alabama at December 31, 2006. There were no pending license applications at December 31, 2006. The Company was allowed to market its products in the following counties: Autauga, Baldwin, Bibb, Blount, Calhoun, Cherokee, Chilton, Cleburne, Coosa, Cullman, Dallas, Dekalb, Elmore, Etowah, Fayette, Greene, Hale, Jefferson, Lamar, Lowndes, Marion, Mobile, Montgomery, Morgan,

Perry, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Washington, Wilcox, and Winston.

The Company has managed care/health contracts in-force. The Company had the following lines of business in 2006: Comprehensive (Hospital & Medical), Title XVIII Medicare, and Other Health (stand-alone prescription drug benefits). The Company discontinued its commercial small business and individual coverage and had only one large group active and six small groups at December 31, 2006. The Company's primary focus was its Medicare business. At the end of 2005, the Company made the operational decision to shift its primary focus of business to its Medicare Advantage product lines with the discontinuance of commercial benefits offered to individuals and small group employers in Alabama effective June 1, 2006. Prior to June 1, 2006, small employer groups currently enrolled in the Company's commercial plan could elect to continue participating in the Company's plans through June 30, 2007. Effective January 1, 2006, the Company began offering a Medicare Prescription Drug Plan.

Compliance with Agents' Licensing Requirements

An inspection of the Company's records was conducted by the examiners to determine that agents representing the Company were duly licensed and appointed by the State of Alabama. A register of licensed agents was obtained from the Agents' Licensing Division of the Alabama Department of Insurance (ALDOI), consisting of 138 active agents, and was compared to a current list of agents maintained by the Company. From the reconciliation, there were 45 agents that were on the ALDOI's listing that were not on the Company's list of active agents. The examiner determined that the Company provided reasonable explanations and documentation for the agents that were not on the active agents listing (these agents were terminated). There were no other exceptions noted. The Company utilized independent and captive (in house) agents to market and sell its products at December 31, 2006. The total number of agents the Company had licensed at December 31, 2006 was 111.

Individual terminated producer files were reviewed to determine the Company's compliance with the termination notification period and allowance for renewal commissions. During a review of fifty terminated producer files from a population of 200, the examiner noted the following exceptions:

(1) The Company did not maintain evidence of notification sent to the ALDOI for 44 terminated agents from a sample of fifty, which was not in accordance with ALA. CODE § 27-7-30 (e) (2001). According to this statute,

> "Subject to the producer's contract rights, if any, an insurer or authorized representative of the insurer may terminate a producer's appointment at any time. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason shall within 30 days following the effective date of the termination, using a format prescribed by the commissioner, give notice of the termination to the commissioner."

(2) The Company did not maintain evidence of the termination notification sent to 32 terminated agents from the fifty selected in accordance with ALA. CODE § 27-7-30.1 (a) (2001), which states:

> "Within 15 days after making the notification required by subsection (e) of section 27-7-30, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in section 27-7-19, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier."

(3) The Company could not provide one of the terminated agents files from a sample of fifty. The Company is required to comply with the requirements of: ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Policy Forms

The Company did not file any new policy forms to the Alabama Department of Insurance during the examination period. At December 31, 2006, the Company was only issuing Medicare policies. The Company's Medicare policy forms are approved by CMS (Centers for Medicare and Medicaid Services). A sample of fifty advertisements were selected to review in conjunction with the corresponding policy form to determine that the Company appropriately maintained a policy form and evidence of the approved form by CMS for each of its advertisements. For the sample selected, the Company could not provide

evidence that 34 policy forms were approved by CMS, which was not in accordance with the requirements of ALA ADMIN CODE 482-1-079-.15 (1987). According to this regulation,

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

ACCOUNTS AND RECORDS

The Company's principal accounting records were maintained on electronic data processing (EDP) equipment. The Company's finance department was mainly responsible for maintaining the accounting records including the general ledger and supporting ledgers. It was also responsible for the accounting of the Company's investments, assets and liabilities, processing accounts payable checks, collecting receivables, and preparing and filing the Company's financial statements. The Company's claims processing and information systems were conducted at HealthSpring, Inc.'s corporate office in Nashville, Tennessee., which was approved by the Alabama Department of Insurance on June 10, 2004.

The Company was audited annually by the independent certified public accounting (CPA) firm of KPMG, LLP, Nashville, Tennessee, which conducted the Company's audits for the two-year period covered by this examination. All audit work papers for 2005 and 2006 were made available for review during the course of the examination. The work papers were tested and utilized in this examination to the extent deemed appropriate. The 2006 management letter and the audit reports issued by the CPAs were reviewed for the examination period.

The Company's reserve calculations for the two-year period under examination were certified by David L. Terry, Jr., A.S.A., M.A.A.A. of NewQuest, LLC.

The Company's Information System Management indicated that the Company has not recently tested its business contingency plan to insure all significant business activities work properly.

The Company's record retention policy states that all documents would be maintained for a period of seven years; however, Board and Board Committee

Materials, Marketing and Sales Documents, and Contracts were documented in the policy as being maintained for three years. All documents are required to be maintained for five years in accordance with requirements of ALA. ADMIN. CODE 482-1-118-.03 (1999), which states:

> "Every insurer, which term shall include every domestic insurer, foreign insurer, health care services corporation, health maintenance organization, prepaid dental plan, managing general agent or any other legal entity regulated by the Insurance Code and licensed to do business in this state shall maintain its books, records, documents and other business records in order that the insurer's financial condition may be readily ascertained by the Department of Insurance, taking into consideration other record retention requirements. All records must be maintained for not less than five (5) years."

The Company did not provide or maintain certain detailed records as of year-end. Consequently, the reconciliation of various records caused the examiners' documentation reviews to progress slowly. Also, the Company did not always provide requested information within ten working days, as is required by Section 6 of Alabama Department of Insurance Regulation No. 118, which states:

> "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the commissioner. ..."

This was also noted in the two prior examination reports. During this examination, the Company did not always respond or provide information within ten working days; however, a significant improvement was noted in overall response time.

Some of the requested supporting documentation was not maintained by the Company, which was not in accordance with ALA. ADMIN. CODE 482-1-079-.15 (1987) that states:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

This was also noted in the two prior examination reports. See the "Notes to the Financial Statements" on page 37 for the specific detail.

FINANCIAL STATEMENTS

Financial statements included in this report, which reflect the financial condition of the Company at December 31, 2006, and its operations for the years under examination, consist of the following:

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS ARE AN INTEGRAL PART THEREOF.

HEALTHSPRING OF ALABAMA, INC.
STATEMENT OF ASSETS
For the Year Ended December 31, 2006

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds **(Note 1)**	$ 8,808,718	$ 0	$ 8,808,718
Cash ($42,099,492), cash equivalents ($31,625,701) and short-term investments ($274,643) **(Note 2)**	73,999,836	0	73,999,836
Rounding	1	0	1
Subtotals, cash and invested assets	$82,808,555	$ 0	$82,808,555
Investment income due and accrued	122,034	0	122,034
Premiums and considerations: Uncollected premiums and agents' balances in the course of collection **(Note 3)**	1,156,480	344,541	811,939
Net deferred tax asset	2,018,574	1,290,660	727,914
Receivables from parent, subsidiaries and affiliates	3,225,691	0	3,225,691
Healthcare and other amounts receivable **(Note 4)**	1,816,098	174,490	1,641,608
Total assets	$91,147,432	$1,809,691	$89,337,741

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

HEALTHSPRING OF ALABAMA, INC.
STATEMENT OF LIABILITES, CAPITAL AND SURPLUS
For the Year Ended December 31, 2006

	Covered	Uncovered	Total
Claims unpaid **(Note 5)**	$23,030,706	$4,098,207	$27,128,913
Accrued medical incentive pool and bonus	1,353,392	0	1,353,392
Unpaid claims adjustment expenses	477,096	0	477,096
Aggregate health policy reserves **(Note 6)**	70,543	0	70,543
Premiums received in advance	1,052	0	1,052
General expenses due and accrued	333,025	0	333,025
Amounts due to parent, subsidiaries and affiliates **(Note 7)**	2,446,838	0	2,446,838
Liability for amounts held under uninsured plans **(Note 8)**	22,966,883	0	22,966,883
Aggregate write-ins for other liabilities **(Note 9)**	7,323,568	0	7,323,568
Total Liabilities	$58,003,103	$4,098,207	$62,101,310
Capital and Surplus:			
Common capital stock			$ 112,400
Gross paid in and surplus			5,010,875
Unassigned funds **(Note 10)**			22,113,156
Total capital and surplus			$27,236,431
Total liabilities, capital and surplus			$89,337,741

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTEGRAL PART THEREOF.

HEALTHSPRING OF ALABAMA, INC.
STATEMENT OF REVENUE AND EXPENSES
For the Year Ended December 31, 2006 and 2005

	2006	2005
MEMBER MONTHS	531,392	364,595
Net premium income	$284,665,101	$195,708,335
Aggregate write-ins for other non-health revenues	2,127	4,259
Total revenues	$284,667,228	$195,712,594
Hospital and Medical:		
Hospital/medical benefits	$186,438,141	$147,982,254
Prescription drugs	30,058,111	11,484,268
Incentive pool, withhold adjustments, and bonus amounts	1,718,349	50,000
Subtotal	$218,214,601	$159,516,522
Less:		
Net reinsurance recoveries	-$ 163,563	$ 4,652
Total hospital and medical	$218,378,164	$159,511,870
Claim adjustment expenses, including $143,709 cost containment expenses	$ 8,008,457	$ 5,620,181
General administration expenses	35,172,757	26,167,494
Increase in reserves for life and accident and health contracts	-241,944	312,487
Total underwriting deductions	$261,317,434	$191,612,032
Net underwriting gain or (loss)	$ 23,349,794	$ 4,100,562
Net investment income earned	$ 2,119,800	$ 766,078
Net realized capital gains or (losses)	679	0
Net investment gains or (losses)	$ 2,120,479	$ 766,078
Federal and foreign income taxes incurred	9,677,879	1,912,978
Net income (loss)	$ 15,792,394	$ 2,953,662

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

HEALTHSPRING OF ALABAMA, INC.
STATEMENT OF CHANGES IN CAPITAL AND SURPLUS
For the Year Ended December 31, 2006 and 2005

	2006	2005
Capital and surplus prior reporting year	$10,811,370	$ 7,677,881
GAINS AND LOSSES TO CAPITAL & SURPLUS:		
Net income or (loss)	15,792,394	$ 2,953,662
Net unrealized capital gains and losses		
Change in net deferred income tax	-256,411	204,529
Change in nonadmitted assets	889,078	-730,417
Change in surplus notes		
Cumulative effect of changes in accounting principles		705,715
Capital changes:		
Paid in	0	0
Net change in capital and surplus	$16,425,061	$ 3,133,489
Capital and surplus end of reporting year	$27,236,431	$10,811,370

THE NOTES IMMEDIATELY FOLLOWING THE FINANCIAL STATEMENTS IN THIS REPORT ARE AN INTERGRAL PART THEREOF.

NOTES TO THE FINANCIAL STATEMENTS

Note 1- Bonds **$8,808,718**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company reported NAIC designations of 1FE instead of 2FE for two of its securities within its 2006 Schedule D- Part 1, which was not in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office. The difference between these NAIC designations did not result in a change to the Company's 2006 financial statements. The incorrect reporting of NAIC designations was also noted in the prior examination report.

While reconciling the Company's December 31, 2006 bonds from the last examination date (as of December 31, 2004), the examiners noted that the Company did not report two of its bonds with maturities in 2005 within its 2005 Schedule D- Part 4 nor did it report the disposal of two of its bonds within its 2005 Schedule D-Part 4, which was not in accordance with the NAIC Annual Statement Instructions. The Company also did not report three of its 2005 bond acquisitions within Schedule D-Part 3, which was also not in accordance with the NAIC Annual Statement Instructions.

During a review of 32 bond acquisitions during the examination period, the examiners determined the following:

1. the Company recorded one cusip number incorrectly, which was not in accordance with the NAIC Annual Statement Instructions;
2. for sixteen bonds (the 2005 acquisitions), the Company included accrued interest paid in the actual cost amount, which was not in accordance with the NAIC Annual Statement Instructions; and,
3. the Company utilized the settlement dates instead of the trade dates as the date acquired for 26 bond acquisitions in 2005 and 2006, which was not in accordance with the NAIC Accounting Practices and Procedures Manual- SSAP No. 26, paragraph 4.

These exceptions did not materially affect the Company's financial statements; therefore, no changes were made. The examiners did note that the Company correctly recorded its bond acquisitions after the prior examination report date.

For its bond purchases, the Company did not report the vendors correctly within its Schedule D- Part 3 for 2005 or 2006, which was not in compliance with the NAIC Annual Statement Instructions.

The Company amortized three of its bonds with call provisions and that were purchased at a premium to their maturity dates. According to SSAP No. 26, paragraph 6, "Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)." The total difference in the amortized values between the call dates and the maturity dates was determined to be immaterial; therefore, no changes were made to the Company's financial statements.

The Company was not in compliance with NAIC Accounting Practices and Procedures Manual SSAP No. 43, paragraphs 10 through 15 because it did not determine prepayment assumptions for its loan-backed securities and review the results periodically.

Note 2- Cash **$42,099,492**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company did not include the amounts within the "Totals of Depository Balances on the Last Day of Each Month During the Current Year" schedule nor in the "Amount of Interest Received During Year" column within its 2006 Schedule E- Part 1, which was not in accordance with the NAIC Annual Statement Instructions. According to Company management, these amounts were inadvertently omitted.

The Company did not perform bank reconciliations for each of its AmSouth Bank accounts separately. These bank accounts were reconciled as though they were one account. This was noted in the prior three examination reports.

The Company reported its repurchase agreement net of the Company's cash account on Schedule E - Part 1 at December 31, 2006. However, according to the NAIC Annual Statement Instructions, the Company was to report repurchase agreements on Schedule E - Part 2 as a cash equivalent because it had a maturity date of three months or less. This misclassification had no effect on the Company's surplus.

Note 3- Uncollected premiums and agents' balances in the course of collection **$811,939**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company was unable to convert the aging detail for $213,035 of this asset into a readable format. This portion of the asset was for the Medicare Part D member premiums receivable, was nonadmitted at December 31, 2006, and was included within the $344,541 discussed below. The Company should however maintain detail in a readable format to support this asset in accordance with ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

The Company nonadmitted $344,541 in uncollected premiums. According to Company management, these nonadmitted premiums were determined to have no probable economic benefit. According to SSAP No. 4, paragraphs 2 and 4 of the NAIC Accounting Practices and Procedures Manual, "2. For purposes of statutory accounting, an asset shall be defined as: probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. ... 4. Transactions which do not give rise to assets as defined in paragraph 2 shall be charged to operations in the period the transactions occur. ..." Since the $344,541 had no probable economic benefit, this amount should have been charged against operations and should not have been nonadmitted. As this had no effect on Unassigned funds and the amount was immaterial, there were no changes reflected within the financial statements contained within this report.

Note 4- Health care and other amounts receivable **$1,641,608**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company did not accurately age its pharmaceutical rebates within its 2006 Exhibit 3. The Company was provided with the totals for Medicare Part D and Part D- Stand alone business from HealthSpring, Inc, but did not receive the

accurate aging. It aged the receivables according to the month the actual rebate was accrued.

The Company did not nonadmit pharmaceutical rebates totaling $147,417 that were over ninety days past due, which was not in accordance with the NAIC Accounting Practices and Procedures Manual- SSAP No. 84, paragraph 10b. This amount was determined to be immaterial; therefore, no changes were made to the Company's financials.

According to the NAIC Accounting Practices and Procedures Manual SSAP No. 84, paragraph 24, "The financial statements shall disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables. Furthermore, for the most recent three years and for each quarter therein, the reporting entity shall also disclose the following:

a. Estimated balance of pharmacy rebate receivable as reported on the financial statements;
b. Pharmacy rebates as invoiced or confirmed in writing; and
c. Pharmacy rebates collected."

In Note 28 of the Company's 2006 Notes to the Financial Statement, the Company did not disclose the method it used to estimate its pharmaceutical rebate receivables and only disclosed the requirements under a., b., and c. for 2006 and the quarters therein and not for the prior two years' quarters, which was required by the aforementioned SSAP and the NAIC Annual Statement Instructions.

The Company's pharmaceutical rebate agreements were maintained by the Pharmacy Rebate Administrator at HealthSpring, Inc., which is located in Nashville, Tennessee. Not maintaining these agreements in Alabama was not in accordance with ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Note 5- Claims unpaid **$27,128,913**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The detail provided for the Company's 2006 Claims paid was $199,478 more than the $213,222,742 reported in its 2006 Underwriting and Investment Exhibit- Part 2, line 1.1. This amount was determined to be immaterial; however, the Company should maintain the complete detail in accordance with ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Within its 2006 Exhibit 4 - Claims Unpaid and Incentive Pool, Withhold and Bonus (Reported and Unreported), the Company aged its unpaid claims from their service dates, which was not in accordance with the NAIC Annual Statement Instructions. According to the NAIC Annual Statement Instructions, the Company is to begin aging claims payable from the date of the receipt of the claim. There were no changes made to the Company's financials due to this incorrect presentation.

Note 6- Aggregate health claim reserves **$70,543**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company did not complete the footnote in Part 2D of its 2006 Underwriting and Investment Exhibit - Aggregate Reserve for Accident and Health Contracts Only. This footnote should be completed in accordance with the NAIC Annual Statement Instructions.

Note 7- Amounts due to parent, subsidiaries and affiliates **$2,446,837.84**

The captioned amount is the same as reported by the Company in its 2006 Annual Statement.

The Company included amounts resulting from its intercompany tax agreement in the captioned account instead of in the Current federal and foreign income

tax payable and interest thereon liability, which was not in accordance with the NAIC Annual Statement Instructions. This misclassification did not affect the Company's surplus; therefore, there were no changes made to the Company's financials.

Note 8- Liability for amounts held in uninsured plans **$22,966,883**

The captioned amount is $1,644,921 more than the $21,321,962 reported by the Company in its 2006 Annual Statement.

This liability was related to Part D payments (prescription drug benefits) from Centers for Medicare and Medicaid Services (CMS) for claims the Company paid for which it assumed no risk, including reinsurance and low-income cost subsidies. The Company accounted for these subsidies as funds held for the benefit of members in this liability. The Company did not recognize premium revenue or claims expense for these subsidies as these amounts represented pass-through payments from CMS to fund deductibles, co-payments, and other member benefits. The Company provided documentation supporting the subsequent settlement with CMS for this liability, which resulted in an understatement of $1,644,921.

Note 9- Aggregate write-ins for other liabilities **$7,323,568**

The captioned amount is $1,420,137 more than the $5,903,431 reported by the Company in its 2006 Annual Statement.

This liability was related to estimated risk corridor adjustments and arose as a result of the Company's actual costs to date in providing Medicare prescription drug benefits (Part D) lower than its bids to Centers for Medicare and Medicaid Services (CMS). The Company did not provide the detail supporting this estimated liability, which was not in accordance with ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

The Company did however provide documentation supporting the subsequent settlement with CMS for this liability, which resulted in an understatement of $1,420,137.

Note 10 - Unassigned funds (surplus) $22,113,156

The unassigned funds (surplus) balance of the Company, as determined by this examination, was $3,065,058 less than the $25,178,214 reported by the Company in its 2006 Annual Statement. The following presents a reconciliation of unassigned funds per the Company's filed Annual Statement to that developed by this examination:

Unassigned funds balance per Company		**$25,178,214**
Examination (increase)/ decrease to liabilities:		
Liability for amounts held under uninsured plans	**-$1,644,921**	
Aggregate write-ins for other liabilities	**-$1,420,137**	
Total increase to liabilities		**-3,065,058**
Unassigned fund balance per Examination		**$22,113,156**

SUBSEQUENT EVENTS

Transfer of Prescription Drug Program Business

On January 1, 2007, HealthSpring of Tennessee, Inc. became a national Prescription Drug Program (PDP) provider. Effective this same date, the Company assigned its stand-alone PDP business to HealthSpring of Tennessee, Inc.

Litigation Settlement

By confidential agreement dated February 20, 2007, a settlement agreement was reached for the settlement of the claims that were pending in the Circuit Court of Wilcox County, Alabama. HealthSpring, Inc.'s Errors and Omissions Insurer, Capitol Specialty Insurance Corporation, through its administrator, Darwin Professional Underwriters, Inc., funded the majority of the settlement proceeds with HealthSpring, Inc. contributing the remaining.

New Home Office Location

In October 2007, the Company moved its home office from Birmingham, Alabama to 2 Chase Corporate Drive, Suite 300; Hoover, Alabama 35244.

CONTINGENT LIABILITIES AND PENDING LITIGATION

The review of contingent liabilities and pending litigation included an inspection of representations made by management and the Company's legal counsel and a general review of the Company's records and files conducted during the examination.

The Company has four pending lawsuits subsequent to the examination date in the Circuit Court of Dallas County and Perry County and U.S. District Court for Alabama, arising out of the marketing of HealthSpring's Medicare Advantage product, Seniors First. The plaintiffs in all four cases are represented by common counsel, and the complaints are nearly identical.

The Company and the independently contracted sales representatives, who enrolled the plaintiffs into Seniors First, are named as the defendants. While asserting a number of state law theories, the allegations focus on two primary claims: (1) alleged misrepresentations by the sales representatives in enrolling the plaintiffs into Seniors First; and (2) alleged negligence and/or wantonness in the hiring, training and supervision of the sales representatives. The Company has filed answers in all four cases, denying all wrongdoing and asserting various affirmative defenses. The Company intends to vigorously defend these lawsuits.

The Pending Litigation is in the early stages. The parties have exchanged paper discovery with no depositions being taken. Due to the unpredictable nature of litigation, the Company and its attorneys have deemed it is impossible to evaluate the likelihood of an unfavorable outcome or to estimate the amount or range of potential loss.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted during the current examination with regard to the Company's compliance with the recommendations made in the previous examination report. This review indicated that the Company had satisfactorily complied with the prior recommendations, with the exception of the following:

Corporate Records

During the prior examination, it was recommended that the Company hold its annual shareholder's meetings for the election of directors and the transaction of general business in January of each year in accordance with the Company By-laws; that the Company hold its annual Board of Directors meeting immediately

following the annual shareholder's meeting in accordance with Company By-laws; and that investments made by the Company be authorized, approved or ratified by the board of directors in accordance with ALA. CODE § 27-41-5 (1975), which states:

> "An insurer shall not make any investment or loan, other than loans on policies or annuity contracts, unless the same be authorized, approved or ratified by the board of directors of the insurer or by such committee..."

During this examination, the Company did not hold its annual Board meetings in January during the examination period, the Company's shareholder had no meetings during the examination period, and the Company's Board did not approve its investments during the examination period. See "Corporate Records" on page 8.

Conflict of Interest

During the last examination, it was recommended that the Company have its officers, directors, and responsible employees complete conflict of interest statements and maintain these statements. During this examination, the Company did not provide conflict of interest statements for all officers and directors. See "Conflict of Interest" on page 12.

Reinsurance

During the prior examination, it was recommended that the Company disclose the required reinsurance information in the Notes to the Financial Statement in accordance with the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual- SSAP No. 61, paragraph 60. It was also recommended that the Company report its reinsurance amounts in the appropriate exhibits and complete Schedule S in future financial statements in accordance with the NAIC Annual Statement Instructions. For this examination, the examiners determined that the Company did not disclose the required reinsurance information in its Notes to the Financial Statement, and it did not correctly report its reinsurance premiums within its Statement of Revenue and Expenses nor in its Schedule S- Part 3- Section 2. See "Reinsurance" on page 22.

Complaint Handling

The prior two examination reports recommended that the Company provide its enrollees with contact information for the Alabama Department of Insurance, Consumer Division when complaints are made, in accordance with the NAIC Market Conduct Examiners Handbook- Complaint Handling, Standard 2. During this examination, the Company did not provide its enrollees with

contact information for the Alabama Department of Insurance, Consumer Division. See "Complaints Handling" on page 24 for further detail.

Compliance with Agents' Licensing Requirements

The prior examination report recommended that the Company maintain documentation of termination notices that were mailed to terminated producers and the Alabama Department of Insurance in accordance with ALA. ADMIN. CODE 482-1-079-.15. During this examination, the Company could not provide evidence of termination notifications for 32 of the fifty sampled files selected.

The prior examination report also recommended that the Company should give notice of the agent's termination to the commissioner within thirty days following the effective date of the agent's termination in accordance with ALA. CODE § 27-7-30 (e) (2001). During this examination, documentation that the Company notified the Commissioner of its terminated agents was provided for six out of a sample of fifty.

ACCOUNTS AND RECORDS

The prior examination recommended that the Company test its business contingency plan to ensure that all significant business activities, including financial functions, telecommunication services, and data processing and network services work properly. This examination noted that the Company had not recently tested its business contingency plan (disaster recovery plan). See "ACCOUNTS AND RECORDS" on page 30 for further commentary.

The prior examination recommended that the Company maintain complete and accurate records in its Alabama home office in accordance with ALA. ADMIN. CODE 482-1-079-.15 (1987). During this examination, the Company did not maintain complete and accurate records of its assets, transactions and affairs in accordance with ALA. ADMIN. CODE 482-1-079-.15 (1987) that states:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state, and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

During the prior examination, it was also recommended that the Company comply with Alabama Department of Insurance Regulation No. 118, by providing responses within ten working days regarding information requested by personnel representing the Alabama Department of Insurance. During this

examination, the Company did not always respond or provide information within ten working days; however, a significant improvement was noted in overall response time.

Bonds

During the prior examination, it was recommended that the Company correctly report NAIC designations for its securities in accordance with the NAIC Purposes and Procedures Manual of the Securities Valuation Office. During this examination, the Company did not report NAIC designations for all of its securities in accordance with the NAIC Purposes and Procedures Manual of the Securities Valuation Office. See "Note 1- Bonds" on page 37.

Cash

During the prior two examinations, it was recommended that the Company reconcile each bank account separately rather than having one reconciliation per bank. During this examination, the Company did not reconcile each bank account separately. See "Note 2- Cash" on page 38.

COMMENTS AND RECOMMENDATIONS

CORPORATE RECORDS – Page 8

It is recommended that the Company hold its annual shareholder's meetings for the election of directors and the transaction of general business in January of each year in accordance with the Company By-laws.

It is recommended that the Company hold its annual Board of Directors meeting immediately following the annual shareholder's meeting in accordance with Company By-laws.

It is recommended that investments made by the Company be authorized, approved or ratified by the board of directors in accordance with ALA. CODE § 27-41-5 (1975), which states:

> "An insurer shall not make any investment or loan, other than loans on policies or annuity contracts, unless the same be authorized, approved or ratified by the board of directors of the insurer or by such committee..."

Board of Directors - Page 9

It is recommended that the Company's shareholder only elect three directors pursuant to its Articles of Incorporation and Bylaws.

It is recommended that the Company's President and Chief Executive Officer be the same individual in accordance with the Company's Bylaws.

Officers – Page 12

It is recommended that the Company's Board elect a Vice-Chairman in accordance with Article V Section 1 of its By-laws.

Conflict of Interest – Page 12

It is again recommended that the Company have its officers, directors and responsible employees complete conflict of interest statements and maintain these statements.

Organizational Chart- Page 13

It is recommended that the Company include the person(s) deemed to be the Company's ultimate parent or controlling person(s) in its Schedule Y- Part 1 in accordance with the NAIC Annual Statement Instructions for future financial filings.

Ceded Reinsurance - Page 22

It is recommended that the Company file all of its reinsurance agreements with the Alabama Department of Insurance for approval in accordance with ALA. CODE § 27-21A-2 (e) (1986), which states "An applicant, or a health maintenance organization holding a certificate of authority granted hereunder shall file with the commissioner all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modification thereto must be approved by the commissioner."

It is recommended that the Company disclose the required reinsurance information in the Notes to the Financial Statements in accordance with the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual- SSAP No. 61, paragraph 60.

It is recommended that the Company report its reinsurance amounts in the appropriate exhibits and complete Schedule S in future financial statements in accordance with the NAIC Annual Statement Instructions.

Complaint Handling – Page 24

It is recommended that the Company maintain all complaint files in accordance with the requirements of ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

It is again recommended that the Company provide its enrollees with contact information for the Alabama Department of Insurance- Consumer Division, when complaints are made in accordance with NAIC's Market Conduct Examiner's Handbook, Complaint Handling, Standard 2.

It is recommended that the Company maintain the required information in both the Commercial/Medicare Provider and Solutions Unit complaint registers in accordance with the following:

(a) the guidelines of the NAIC Unfair Trade Practices Act, Section 4, which state: "This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint."

(b) the guidelines of the NAIC Market Conduct Examiners Handbook, which state: "All complaints are recorded in the required format on the Company Complaint Register."

The Company's complaint register is required to include the following: the complainant's first and last name, type of coverage, date of complaint, policy number, complaint form (how the complaint was received), type of complaint, disposition, date of response, and complainant type.

Compliance with requirements of ALA. ADMIN. CODE 482-1-121 (2003) – Page 25

It is recommended that the Company institute a screening mechanism to attempt to identify prohibited persons as required by ALA. ADMIN. CODE 482-1-121 (2003), which states that:

> "...Failure to inform the Department of a prior felony conviction on a license application could result in a violation of this statute, as well as constitute grounds for denial of an insurance license. Insurance companies, as well as persons employing anyone to conduct the business of insurance may be in violation of this statute if they willfully permit participation by a prohibited person, including persons who are already employed or being considered for employment. Failure to initiate a screening process in an attempt to identify prohibited persons in current or prospective employment relationships may be a factor in determining if a violation of this statute has occurred. ..."

Compliance with Agents' Licensing Requirements - Page 28

It is recommended that the Company maintain evidence in each terminated agent's file of the termination notification sent to the ALDOI Commissioner in accordance with ALA. CODE § 27-7-30 (e) (2001), which states:

> "Subject to the producer's contract rights, if any, an insurer or authorized representative of the insurer may terminate a producer's appointment at any time. An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason shall within 30 days following the effective date of the termination, using a format prescribed by the commissioner, give notice of the termination to the commissioner."

It is recommended that the Company maintain evidence in each terminated agent's file of the termination notification sent to each terminated agent in accordance with ALA. CODE §27-7-30.1 (a) (2001), which states:

> "Within 15 days after making the notification required by subsection (e) of section 27-7-30, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in section 27-7-19, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier."

It is also recommended that the Company maintain all terminated agent's files in accordance with the requirements of ALA. ADMIN CODE 482-1-079-.15 (1987), which states:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Policy Forms- Page 29

It is recommended that the Company maintain in its files the policy forms and copies of CMS's approval of these policy forms for each of the advertisements that are used to market and solicit business in accordance with the requirements of ALA ADMIN CODE 482-1-079-.15 (1987), which states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

ACCOUNTS AND RECORDS – Page 30

It is recommended that the Company test its business contingency plan to ensure that all significant business activities, including financial functions, telecommunication services, and data processing and network services work properly on a consistent basis.

It is recommended that the Company modify its record retention policy so that the policy complies with the timeframe specified by ALA. ADMIN. CODE 482-1-118-.03 (1999), which states:

> "Every insurer, which term shall include every domestic insurer, foreign insurer, health care services corporation, health maintenance organization, prepaid dental plan, managing general agent or any other legal entity regulated by the Insurance Code and licensed to do business in this state shall maintain its books, records, documents and other business records in order that the insurer's financial condition may be readily ascertained by the Department of Insurance, taking into consideration other record retention requirements. All records must be maintained for not less than five (5) years."

It is again recommended that the Company maintain complete and accurate records in accordance with ALA. ADMIN. CODE 482-1-079-.15 (1987), which states:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

It is again recommended that the Company provide responses within ten working days for information requested by personnel representing the Alabama Department of Insurance in accordance with Section 6 of Alabama Department of Insurance Regulation No. 118, which states:

> "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the commissioner."

Bonds - Page 37

It is again recommended that the Company correctly report NAIC designations for its securities in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office.

It is recommended that the Company reflect all investment acquisitions and disposals within the appropriate investment schedules in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company record cusip numbers correctly for its bond acquisitions within Schedule D in accordance with the NAIC Annual Statement Instructions; not include the accrued interest paid within the actual cost amount in Schedule D- Part 3 in accordance with the NAIC Annual Statement Instructions; and, utilize and record the trade date as the date acquired for bond acquisitions in Schedule D, in accordance with the NAIC Accounting Practices and Procedures Manual- SSAP No. 26, paragraph 4.

It is recommended that the Company correctly report the vendors from whom its purchases its securities within Schedule D- Part 3 in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company amortize its bonds with call provisions in accordance with the NAIC Accounting Practices and Procedures Manual-SSAP No. 26, paragraph 6, which states:

> "Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

It is recommended that the Company determine prepayment assumptions for its loan-backed securities and review the results periodically in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 43, paragraphs 10 through 15.

Cash – Page 38

It is recommended that the Company complete the "Totals of Depository Balances on the Last Day of Each Month During the Current Year" schedule and the "Amount of Interest Received During Year" column within its Schedule E- Part 1 in accordance with the NAIC Annual Statement Instructions.

It is again recommended that the Company reconcile each bank account separately rather than having one reconciliation per bank. This was noted in the prior two examination reports.

It is recommended that the Company report its repurchase agreement on Schedule E – Part 2 in future financial filings in accordance with the NAIC Annual Statement Instructions.

Uncollected premiums and agents' balances in the course of collection-Page 39

It is recommended that the Company maintain the detail supporting its Uncollected premiums and agents balances in the course of collection in accordance with ALA ADMIN CODE 482-1-079-.15 (1987). This regulation states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

It is recommended that if the Company has uncollected premiums that are determined to have no probable economic benefit that the Company comply with the NAIC Accounting Practices and Procedures Manual - SSAP No. 4, paragraphs 2 and 4, which states:

> "2. For purposes of statutory accounting, an asset shall be defined as: probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events. ... 4. Transactions which do not give rise to assets as defined in paragraph 2 shall be charged to operations in the period the transactions occur. ..."

Health care and other amounts receivable- Page 39

It is recommended that the Company correctly reflect the aging of its pharmaceutical rebates in its Exhibit 3 for future financial filings in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company nonadmit all pharmaceutical rebates that have not been collected within ninety days of the invoice date or confirmation date in accordance with the NAIC Accounting Practices and Procedures Manual- SSAP No. 84, paragraph 10b.

It is recommended that the Company disclose the following information for its pharmaceutical rebate receivables that is required by the NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual -SSAP No. 84, paragraph 24 in its Notes to the Financial Statement:

> "The financial statements shall disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables. Furthermore, for the most recent three years and for each quarter therein, the reporting entity shall also disclose the following:
>
> a. Estimated balance of pharmacy rebate receivable as reported on the financial statements;
> b. Pharmacy rebates as invoiced or confirmed in writing; and
> c. Pharmacy rebates collected."

It is recommended that the Company maintain its pharmaceutical rebate agreements at its home office in accordance with ALA ADMIN CODE 482-1-079-.15 (1987), which states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such

methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

Claims unpaid - Page 41

It is recommended that the Company maintain the complete detail of its paid claims that reconciles to its Underwriting and Investment Exhibit- Part 2 in accordance with ALA ADMIN CODE 482-1-079-.15 (1987), which states that:

"Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

It is recommended that the Company begin aging its unpaid claims within its future financial filings from the date of the receipt of the claims in accordance with the NAIC Annual Statement Instructions.

Aggregate health claim reserves- Page 41

It is recommended that the Company correctly complete the footnote "(a) Includes $_____ premium deficiency reserves" rather than leaving it blank in accordance with the NAIC Annual Statement Instructions.

Amounts due to parent, subsidiaries and affiliates- Page 41

It is recommended that the Company not include amounts resulting from its intercompany tax agreement within the Amounts due to parent, subsidiaries and affiliates nor in its Receivable from parent, subsidiaries and affiliates line items but classify these amounts within the appropriate federal tax line items in accordance with the NAIC Annual Statement Instructions.

Liability for amounts held in uninsured plans - Page 42

It is recommended that the Company establish adequate accruals for its Liability for amounts held in uninsured plans related to the Medicare prescription drug benefits in future financial filings.

Aggregate write-ins for other liabilities - Page 42

It is recommended that the Company maintain detailed support for its Aggregate write-ins for other liabilities in accordance with ALA ADMIN CODE 482-1-079-.15 (1987), which states that:

> "Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted."

It is recommended that the Company establish adequate accruals for its risk corridor adjustments related to Medicare prescription drug benefits in future financial filings.

CONCLUSION

The customary examination procedures, as recommended by the National Association of Insurance Commissioners for health maintenance organizations, have been followed in connection with the verification and valuation of assets and the determination of liabilities set forth in this report.

In addition to the undersigned, the following persons represented the Alabama Department of Insurance as participants in this examination: Juliette Glenn, examiner; Michael Masuen, CFE, AES, CISA, information systems examiner; and Harland A. Dyer, ASA, MAAA, FCA, actuarial examiner.

Respectfully submitted,

Rhonda B. Ball
Examiner-in-Charge
Alabama Department of Insurance